CITY CHIROPRACTIC • Jackson Tower • 806 SW Broadway • Suite 350 • Portland, OR 97205 • 503/224-9513

CONFIDENTIAL PATIENT INFORMATION

TODAY'S DATE _____ BIRTH DATE _____

DRIVER'S LIC # _____ SEX ☐ M ☐ F

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

NAME _____ SPOUSE'S NAME _____

ADDRESS _____ GUARDIAN'S NAME _____

CITY/STATE/ZIP _____ E-MAIL ADDRESS _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMPLOYER _____

EMERGENCY CONTACT PERSON AND PHONE _____

INJURY/ACCIDENT REPORT

ONLY FILL OUT THIS SECTION IF INVOLVED IN AN AUTO OR WORK RELATED INJURY

WAS INJURY CAUSED BY: ☐ AUTO ACCIDENT ☐ EMPLOYEE ACCIDENT ☐ OTHER _____

DATE OF INJURY _____

IF YOUR INJURY WAS WORK RELATED, PLEASE LIST NAME, ADDRESS AND PHONE OF YOUR EMPLOYER:

NAME _____

ADDRESS _____

_____ PHONE _____

IF YOUR INJURY WAS AUTO RELATED, PLEASE LIST LOCATION OF ACCIDENT (city, county, state) & NAME(S) OF OTHER PARTY(IES) INVOLVED: _____

_____

_____

_____

RECORDS RELEASE AUTHORIZATION

AS REQUIRED BY THE PRIVACY REGULATIONS, CITY CHIROPRACTIC MAY NOT USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION EXCEPT AS PROVIDED IN OUR NOTICE OF PRIVACY PRACTICES, WITHOUT YOUR AUTHORIZATION.

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

CITY CHIROPRACTIC
806 SW Broadway, Suite 350
Portland, Oregon 97205
503-224-9513 • fax 503-224-9595

THE COMPLETE HISTORY RECORDS AND X-RAYS IN YOUR POSSESSION FOR:

PATIENT NAME (please print) _____ DATE OF BIRTH ____/____/____

SIGNATURE _____

EFFECTIVE DATES OF THIS AUTHORIZATION ____/____/____ THROUGH ____/____/____

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INSURANCE BILLING

PRIMARY

(Patient's Insurance Information)

Insurance Co. Name _____

Billing Address _____

_____

Phone # (to verify eligibility) _____

Name of Insured _____

ID/Policy # _____

Group or Claim# _____

Insurance Agent's Name _____

And Phone number _____

I hereby authorize CITY CHIROPRACTIC to furnish the insured's insurance company all information concerning my present claim.

Signature _____

Date _____

OTHER INSURANCE

Insurance Co. Name _____

Billing Address _____

_____

Phone # (to verify eligibility) _____

Name of Insured _____

ID/Policy # _____

Group or Claim# _____

Insurance Agent's Name _____

And Phone number _____

I hereby authorize CITY CHIROPRACTIC to furnish the insured's insurance company all information concerning my present claim.

Signature _____

Date _____

ASSIGNMENT OF INSURANCE

I HEREBY INSTRUCT MY INSURANCE COMPANY TO PAY DIRECTLY TO CITY CHIROPRACTIC ALL MONEY TO WHICH I AM ENTITLED FOR EXPENSES RELATED TO THE SERVICES PERFORMED, BUT NOT TO EXCEED MY INDEBTEDNESS TO CITY CHIROPRACTIC. I UNDERSTAND THAT ANY SUM OF MONEY PAID UNDER THIS ASSIGNMENT SHALL BE CREDITED TO MY ACCOUNT AND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY UNPAID BALANCE NOT COVERED BY THE ASSIGNMENT AND/OR NOT PAID BY THE INSURANCE COMPANY.

PATIENT AGREES TO PAY AND DISCHARGE ALL COSTS AND EXPENSES INCURRED BY CITY CHIROPRACTIC, INCLUDING REASONABLE ATTORNEY'S FEES THAT SHALL ARISE AS A RESULT OF ATTEMPTS TO FORCE PATIENT TO HONOR HIS/HER FINANCIAL OBLIGATIONS TO CITY CHIROPRACTIC, EVEN THROUGH NO SUIT IS INSTITUTED.

SIGNATURE _____ DATE _____

WITNESS _____

ADJUSTING ROOM ENVIRONMENT

In Chiropractic facilities around the world there are 3 commonly used adjusting room environments.

1) **An "open" adjusting room environment.** This is when there are many chiropractic adjusting tables in one room and there are no partitions or dividers separating the tables.
2) **A "semi-open" adjusting room environment.** This is when there are several adjusting tables in an area that has partitions or dividers separating each adjusting table/room.
3) **A "closed" adjusting room environment.** This is when all adjusting tables/rooms are completely separated and private.

City Chiropractic is currently utilizing a "semi-open" adjusting room environment for ongoing patient care. As mentioned above, this involves several patients being seen in the same area **separated by partitions.** As a result, patients are occasionally within sight or sound of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used only for ongoing care and is NOT the environment used for taking patient histories, providing examinations, or presenting reports of findings. These particular procedures are completed in a private, confidential setting.

If there is a private or confidential issue that needs to be discussed with one of the doctors during one of your ongoing care visits, please inform the staff and an arrangement will be made to set up a meeting with the doctor either in one of our private rooms or via telephone at a convenient time.

The use of our current "semi-open" format is intended to make your experience with our office more productive as well as to enhance your access to high quality health care and educational health information. If you choose not to be adjusted in our "semi-open" adjusting environment, other arrangements will be made for you.

By my signature below, I hereby understand the above information.

_____	_____	_____
Patient's Name (Please Print)	**Signature**	**Date**

If the patient is a minor, then please provide the patient's name above and parent or guardian's signature below.

_____	_____	_____
Patient's Name (Please Print)	**Signature**	**Date**